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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 09-030-9016
Chicago Read Mental Health Center

Case summary: The HRA did not substantiate that the facility breached the recipient's confidentiality, did not substantiate that the facility denied the recipient the right to use the telephone to report an emergency, however it did substantiate that the facility denied the recipient adequate contact with her social worker.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at the Chicago Read Mental Health Center (Read). It was alleged that:

1. The facility breached confidentiality.
2. The facility denied the recipient the right to use a telephone to report an emergency.
3. The facility denied the recipient adequate and humane treatment by inadequate contact with her social worker.

If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et. seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110 et seq.) and program policies.

Chicago Read Mental Health Center is a 215-bed Illinois Department of Human Services (DHS) facility located in Chicago. To review these complaints, the HRA conducted a site visit and interviewed the Quality Manager and a member of the quality management team. Relevant hospital policies were reviewed, and records were obtained with the consent of the adult recipient.

COMPLAINT SUMMARY

The complaint alleges that the facility breached confidentiality when a staff person discussed another resident within hearing distance of the recipient being admitted onto the unit. Additionally, the complaint alleges that that the recipient was prevented from calling 311 (non-emergency hotline) when an emergency situation involving another recipient took place and she

was told to go to her room. The complaint also alleges that in the three weeks that the recipient was a resident at Read, she met with her social worker only once and he would not meet with her to discuss her discharge plans in retaliation for her complaint against him that she made to the patient representative. It was also alleged that the recipient had to place a note under the social worker's door stating that she would report him if he did not meet with her.

FINDINGS

The record shows that the recipient was voluntarily admitted to Read on 1/01/09 with the presenting problems of auditory and visual hallucinations and an untreated seizure disorder. The complaint alleges that while the recipient was being admitted, she was able to hear two staff members loudly talking about a resident on the unit (B South). With this information the recipient was able to identify the other resident once she was on the unit, and she had personal and private knowledge of the resident which she felt she should not have had. Additionally, the recipient was able to identify the staff person and was uncomfortable in her interactions with her, knowing that she might disclose information or offer opinions about her to other persons. Hospital staff were interviewed about this allegation and they stated that Read has direct admission of recipients to their assigned units and they are interviewed in a "welcome room" by a mental health technician, security staff person, and nursing staff. Although there is only one person in the room at a time, the recipient might have been able to hear conversations from other offices in the adjoining corridor if the door to the room was open. Staff reported that at times recipients are admitted with the door open. Staff were not aware of the specific incident cited here and they reported that it was not brought to their attention.

The record (progress notes made on 1/08/09) indicates that the recipient did have problems interacting with the staff who she overheard at her admission: "….Pt. has been targeting this staff since her arrival on the unit. Even when this staff is engaged with another client pt. tries to get involved seeking attention from staff and being intrusive. When redirected by staff as usual pt. will say 'Stupid at least you could answer me and continue.' This morning she became very belligerent and verbally abusive to staff and threatened 'I will get you fired, I bet you watch.' She continued, 'I have a lawyer and as soon as I got here I called him.' Pt. has been coming to the nursing center demanding service immediately 'I don't care who you are when I need something you better hurry up and give it to me, that is who I am.' She is also threatening to 'make all the social workers and doctors lose their jobs."

The complaint also alleged that the recipient witnessed a crisis involving another recipient on the unit but was prevented from notifying the authorities because she was told to go to her room. There is no incident in the record to indicate that a situation occurred in which the recipient was prevented from calling authorities to report an incident. Hospital representatives stated that if an incident occurs an incident report is completed and if there are injuries, an injury report is completed and the Office of the Inspector General is notified. The recipient's record reflected such an incident on 1/04/09 when the recipient fell after standing up from a chair, hitting her head on the wall behind her. In that incident all the described procedures were

followed, substantiating the practice described by staff. Hospital representatives also indicated that phones are available and free for use at all times, and that calls are restricted only when they become harmful, harassing or intimidating. At these times, a restriction of rights notice would be issued that would become part of the clinical record. There are two wall phones available on each unit at all times.

On 1/20/09 an incident occurred which is described in the nursing notes suggesting that the recipient was prevented from calling 311 however it does not involve an emergency situation or another recipient. It is the only such incident recorded in the notes, and it states:

"*Pt. on routine care and monitoring. Verbal redirection/[illegible] and counseling done, effective. Pt. became loud and demanding …[illegible] to call 311 to ask for seizure care. Pt. verbalized not feeling safe. Staff provided reassurance and explained hospital policy and treatment plan. Pt. able to understand and was given enough time to vent her feelings, staff offered 1:1 counseling, effective. Pt.'s mood labile and behavioral symptoms manageable at this time. No acting out aggressive behaviors. Pt. able to gain insight into her need to manage her anger feelings. Will provide structured activities….*"

Staff reported that it would not be appropriate to notify police or fire personnel for a clinical or medical problem as evidenced in this situation, however they would not prevent a recipient from calling if they wanted to. In this situation counseling was provided to address the patient's concerns and redirect her without further intervention.

Finally, the complaint alleges that in the three weeks that the recipient was a resident on the unit she met with her social worker only once and that the social worker would not meet with the recipient to develop her discharge plan in retaliation for the recipient reporting the social worker to the patient representative. The complaint alleges that the recipient had to place a note under the social worker's door saying that she would report him in order for him to see her. The record does not indicate that the social worker was reported for any reason and there is no documented evidence that he received a note from the recipient.

The record contains the initial Social Assessment completed by the recipient and her social worker dated 1/05/09. In the treatment recommendations and tentative discharge plans section of the assessment it states, "1:1 with treatment to work out treatment and discharge plans. All groups incl [Mental Illness Substance Abuse] and Sober Liesure (sic) Skills and referral to residential SA tx upon discharge." A master treatment plan/initial nursing treatment plan (1/01/09) is included in the record and it does not address the recipient's substance abuse or discharge plans. A treatment plan review, dated 1/16/09 describes the "patient's input into treatment plan." It states, "Pt. states off and on that she wants to get into residential SA treatment but her plans change frequently." In the section named "Aftercare" it states: '"Pt. is ready for discharge to a residential SA program." In the "Current aftercare plans" section it states, "She will work with us to find a SA residential placement. [Another agency] is working toward this end as well." The document indicates that the recipient did not participate in her staffing, but that the plan was reviewed with her. The progress notes do not indicate when or with whom she reviewed her plan. The master treatment plan and the treatment plan review do not specify how often the recipient will meet with the social worker.

The record also shows that the recipient signed a Request for Discharge on 1/02/09 that is also signed by the social worker and then rescinded by the recipient on the same day and this is noted in the progress notes by the mental health technician. There is one entry in the progress notes of a meeting between the recipient and her social worker dated 1/16/09. It states,

"*Met with pt. She asserted that she wanted to stay here to get PA & SSI & a residential substance abuse program & then stated she wanted to go back to her pre admission residence and leave here ASAP. We were then told by the man she had been living with that she absolutely was not welcome to return there until she had completed a residential SA tx program. She states she has not used drugs or alcohol for 30 days. Not a danger to self or others. She has called Legal Assistance services to request a change in treatment coordinators. Will discuss with team and push toward getting her into SA tx with the collaboration of LSSI.*"

Facility representatives were interviewed about the social worker's entry in the notes. They stated that changes of assignment are always a treatment team decision and clinically driven. They noted that problems with various treatment team members can be a result of the recipient's pathology and a change may not be therapeutic. Hospital representatives did acknowledge that there was a "paucity" of documentation by this recipient's social worker, and that since this complaint was made they have developed policy to ensure that social workers must minimally document one meeting per week for those recipients on the acute units. In this case, it is unclear from the record that the social worker developed a referral for the substance abuse treatment that was recommended for the recipient. The recipient signed a request for discharge (the date is unknown), and was then discharged to her pre admission residence on 1/22/09. A late entry made in the progress notes on 1/27/09 indicates that the social worker met with the recipient (date not given). It states:

"*Ms…signed request for discharge and wished to go. Her b.f./fiancé/friend …indicated to me most recently that she could, after all, be discharged to his address in…. She accepted an appointment with... for 1/07/09 at 10:00 a.m. and stated she will continue her efforts to access residential SA treatment with the help of LSSI/LCM. Not a danger to self or others& able to care for self. Discharged 1/22/09."*

STATUTORY BASIS

The Mental Health and Developmental Disabilities Confidentiality Act states that "All records and communications shall be confidential and shall not be disclosed except as provided in this Act" (740 ILCS 110/3a). It also defines "Confidential communication" or "communication" as "any communication made by a recipient or other person to a therapist or to or in the presence of other persons during or in connection with providing mental health or developmental disability services to a recipient. Communication includes information which indicates that a person is a recipient" (110/2).

The Mental Health Code guarantees recipients the right to unimpeded, private and uncensored communication by mail, telephone, or visitation. It also states that this right can only be restricted to prevent harm, harassment or intimidation (405 ILCS 5/2-103).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their treatment and provides for their participation in this process to the extent possible:

"(a) A recipient of services shall be provided with adequate and human care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient". (405 ILCS 5/2-102).

Adequate and humane care is defined as "services reasonably calculated to prevent further decline in the condition of a recipient of services so that he or she does not present an imminent danger to self or others." (5/1-101.2).

The American Counseling Association Code of Ethics Section A.11a. states, "Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination." Also, if counselors determine they are unable to assist their clients, "Counselors are knowledgeable about….clinically appropriate referral resources and suggest these alternatives" (A.11b.).

FACILITY POLICY

The HRA requested in writing and in person the facility policy and procedure that addresses the stated complaints. Facility representatives reported that there is no hospital policy for the number of social worker visits with recipients and their documentation, however they reported that this policy is being developed at this time. The HRA did not receive the hospital policy on confidentiality and phone rights, however the hospital policy guarantees the rights provided by the Mental Health Code and the record contains the signed recipient rights statement.

CONCLUSION

The complaint alleges that the facility breached confidentiality by allowing a situation where a recipient was able to hear a staff person discuss personal and confidential information regarding another recipient, which then affected the recipient's ability to interact with this staff person. Hospital representatives were unable to confirm or deny this allegation, stating that it would be possible to overhear conversations only if the door to the admissions office was ajar. The weight of the overheard information provided to the HRA favors the allegation that confidentiality was breached, however there is no factual evidence to confirm this allegation and thus the HRA does not substantiate the complaint that the facility breached confidentiality.

The second part of the complaint alleges that the facility denied the recipient the right to use a telephone to report an emergency. The HRA was unable to verify from the documented evidence that an emergency such as the one described in the complaint actually occurred and staff assured the HRA that recipients would not be prevented from making these calls, unless they were clearly harmful, harassing or intimidating, which complies with the Mental Health

Code. Additionally they assured the HRA that a Restriction of Rights form would be completed if phone rights were restricted. The HRA does not substantiate the allegation that the facility denied the recipient the right to use a telephone to report and emergency.

The third part of the complaint alleges that the facility denied the recipient adequate and humane treatment by inadequate contact with her social worker. The complaint alleges that in the three weeks that the recipient was a resident at Chicago Read, she met with her social worker only once and he would not meet with her to discuss her discharge plans in retaliation for her complaint against him that she made to the patient representative. It was also alleged that the recipient had to place a note under the social worker's door stating that she would report him if he did not meet with her. The record does not indicate that the social worker was reported for any reason and there is no documented evidence that he received a note from the recipient.

The record does contain an initial social assessment dated 1/05/09 and a treatment plan update dated 1/16/09, and this second meeting is the only documented meeting between the recipient and the social worker in the progress notes. More notably, the initial social assessment, treatment plan review and late entry documentation made by the social worker after the recipient's discharge, all demonstrate the recipient's strong willingness to participate in residential substance abuse treatment, and it does not appear from the record that the social worker made an attempt to secure this referral for the recipient. Given the importance of substance abuse treatment for this recipient and the oftentimes difficult challenge of getting patients to accept residential treatment, it would seem imperative that the social worker secure this referral as soon as the recipient demonstrated willingness. If the social worker met with the recipient regularly, the record demonstrates a lack of documentation to support it. The HRA substantiates the complaint that the facility denied the recipient adequate and humane treatment by inadequate contact with her social worker.

RECOMMENDATIONS

1. Develop policy and procedure for the implementation of a continuum of care which mandates regular meetings between the social worker and their assigned clients and train staff to document these meetings in the clinical record.
2. Include a statement of the need for and the frequency of meetings between recipients and their social workers in recipients' treatment plans.

SUGGESTION

1. Include on treatment plan documentation who is responsible for plan reviews and when they are done.